DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555095	A. BUILDING _____ B. WING _____	04/24/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
N M HOLDERMAN MEMORIAL HOSPITAL D/P SNF	100 CALIFORNIA DRIVE YOUNTVILLE, CA 94599

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F 000	INITIAL COMMENTS The following reflects the findings of the California Department of Public Health during an Annual Recertification Survey. The census was 339 residents. Representing the Department of Public Health: HFEN 6726 HFEN 5008 HFEN 8695 HFEN 12405 HFEN 16550 HFEN 16551 HFEN 16605 HFEN 22327 HFEN 23101	F 000	Preparation and/or execution of this plan of correction does not constitute an admission or agreement by the provider to the truth of the facts alleged or conclusion set forth in the statement of deficiencies. This plan of correction is prepared and/or executed because it is required by the provisions of Health and Safety Code Section 1250 and 42 C.F.R. 405.1907 (JGA) initials This ***Amended*** Plan of Correction constitutes our written credible allegation of compliance for the deficiencies noted.	
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) STAFF TREATMENT OF RESIDENTS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with	F 225	**F 225 Plan of Correction:** The facility will continue to ensure injuries of unknown origin are promptly identified, reported and investigated. CNA Staff 1 was provided individual counseling regarding his/her responsibility for reporting injuries of unknown origin to the charge nurse. The Administrator and Director of Nursing were notified of the injury of unknown origin via the "24 Hour Nursing Report." An intra-facility investigation was initiated on Resident 6 and completed per policy. Nursing Education will provide a mandatory in-service regarding Elder Abuse Prevention, which will address injuries of unknown origin, annually during Required Annual Review.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Jacqueline Anderson | SCC | 6/20/08

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14

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F 225	Continued From Page 1 State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This Requirement is not met as evidenced by: Based on observation, interviews, review of the clinical record and facility documents, the facility failed to ensure that an injury of unknown source was promptly identified, reported and investigated for 1 of 30 sampled residents (Resident 6). Findings: During observations on 4/22/08 at 2 p.m., Resident 6 had a large purplish bruise noted on his left elbow area. During an interview at the same time, the resident stated that he was not aware of it or how it had happened. On 4/23/08 at 2 p.m., review of the record failed to indicate documentation of this injury. During an interview on 4/23/08, at 2 p.m. CNA Staff I stated that he had cared for the resident the prior day and had not noticed the bruise until	F 225	**Continued from page 1:** During a unit based staff meeting, the Supervising Registered Nurses will educate staff on their responsibilities for identifying and reporting injuries of unknown origin. **Responsible:** Regulatory Compliance Nurse and Quality Assurance Nurse **Monitor:** The Regulatory Compliance Nurse and Quality Assurance Nurse will monitor to ensure substantial injuries of unknown source are promptly identified, reported and investigated per protocol. Identified deficiencies will be corrected promptly and forwarded to the Long-Term Care Quality Assurance Committee for appropriate action.	05/21/08

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F 225	Continued From Page 2 approximately 30 minutes ago today. The staff stated that he had not yet reported the observation to the charge nurse or supervisor. During an interview at approximately 2:15 p.m., neither LVN Staff H nor SRN Staff G was aware of the resident's bruise. On 4/24/08 at approximately 10:45 a.m., SRN Staff G stated that a report regarding this injury of unknown source had been initiated and submitted to the Nursing Office. Staff G stated that the documentation of this reporting process could not be shared with the surveyor and SRN Staff L stated that the report was part of Q.A. (Quality Assurance) and could not be shown to the surveyor. During an interview at 3:30 p.m., Staff M with Q.A. stated that there was a misunderstanding however, the documentation was still not forthcoming at that time. Review of the facility policy titled:"Elder Abuse" Nursing 01-050 indicated on page 3 regarding injuries of unknown origin, that the "The Standard Compliance Coordinator reports incidents and injuries to Administration and other agencies as appropriate." According to page 4 of the same policy under 1.6 A #3 the supervisor will "Begin the investigation and complete the appropriate sections of the Unusual Occurrence", and under #5 the supervisor will "Notify the Service Chief and Administrator according to facility protocol." There was no documented evidence presented by the facility to demonstrate that this policy was implemented, to verify notifications were made and that an investigation was inititated in response to this injury of unknown origin.	F 225		

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F 226	Continued From Page 3	F 226	**Continued from page 3:**	
F 226 SS=E	483.13(c) STAFF TREATMENT OF RESIDENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This Requirement is not met as evidenced by: Based on facility document review and interview, the facility failed to operationalize its policy for screening new employees in two out of four personnel records checked. Finding: On 4/24/08 at 8:20 a.m. four randomly sampled new employee personnel files were reviewed. Each file contained an Appointment Authorization form. This form included a section titled, "Fingerprints - Scheduled, Approved." On two of the four forms reviewed (Staff N and Staff O), the fingerprints were not noted as approved. Staff N had a date of hire of 6/18/07 and Staff O had a date of hire of 12/17/07. Staff E, present at the time of the record review, was interviewed. Staff E stated that staff are sent to the facility hospital police office for fingerprinting. The results of the fingerprint check are communicated to the facility personnel office. Someone in the personnel office is responsible for annotating the fingerprint section of the Appointment Authorization form. Staff E could not explain why the fingerprint approval information was missing from the two personnel files.	F 226	**F 226 *Amended* Plan of Correction:** The Facility will implement its policy/procedures for screening new employees. Prospective employees will not start until Human Resources have received clearance from Security. Human Resources will conduct an audit of all patient care employees hired between 04/24/07 and 04/28/08 to ensure all employees fingerprints were screened and cleared through Security. Those prints found to be outstanding will be followed-up through Security. The Transaction Supervisor will initial the fingerprint section on the appointment authorization form after Security verifies fingerprints have been cleared. **Responsible:** Transaction Supervisor **Monitor:** The Transaction Supervisor will monitor the fingerprint clearance section for signature or initials. Data will be reviewed through the Support Services Quality Improvement Committee. Negative findings will be corrected immediately. The indicators for this monitor will continue until we have met or exceeded threshold for one quarter or three consecutive months.	06/30/08

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F 246	Continued From Page 4	F 246	**Continued from page 4:**	
F 246 SS=D	483.15(e)(1) ACCOMMODATION OF NEEDS A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. This Requirement is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure that 2 of 30 sampled residents were properly positioned at dining tables. (Residents 6 & 30). Findings: 1. During lunch observations on 4/21/08 at 11:45 a.m., Resident 6 was seated in a wheel chair that tilted backwards and did not allow his legs to fit underneath the table. The resident had to reach at arm's length to spoon his soup from the bowl to his mouth. The resident stated it was a little far. The SRN Staff G was shown the resident's seating and stated she would have the Occupational Therapist reassess the resident's table seating. Review of the clinical record indicated that the resident ate independently. 2. On 4/24/08 at 8:20 a.m., Resident 30 had just finished breakfast in the dining room. During an interview also at 8:20 a.m., Staff K stated that the resident always eats at the same table. The resident was seated in a wheel chair at a table that was at the height of her shoulders. Staff K stated that Resident 30 can feed herself but staff usually assist her as she needs prompting but can pick up her cup and utensils. During this	F 246	**F 246 Plan of Correction:** The facility will continue to ensure each resident receives reasonable accommodations that meet their individual needs and preferences. **Finding 1.** Resident #6 was promptly evaluated by an Occupational Therapist on 4/23/08 for proper positioning at the dining table. Occupational Therapist recommendations were implemented, including the use of an adjustable height table and the Resident's care plan was updated accordingly. **Finding 2.** Resident #30's dining needs were reassessed promptly. The resident was provided a lap tray for meals and the care plan was updated accordingly. During a unit based staff meeting, the Supervising Registered Nurses will educate staff on their responsibilities for proper positioning of residents during meals. **Responsible:** Supervising Registered Nurse **Monitor:** The Supervising Registered Nurses will randomly monitor meals to ensure proper positioning of residents at the dining tables. Deficient practices will be identified and corrected promptly. This monitor will be completed monthly using the Quality Assurance Environmental Rounds Monitor and findings will be reported through the Long-Term Care Quality Assurance Committee.	05/21/08

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F 246	Continued From Page 5 observation, SRN Staff L agreed that the table was too high and attempted to lower it. The staff was unsuccessful in lowering the table and stated that she would have the resident's dining set up reassessed. Review of the Resident 30's record on 4/23/08 indicated an R.D. (Registered Dietitian) entry dated 4/15/08 that noted "a gradual weight decline this quarter".	F 246	**Continued from page 5:**	
F 272 SS=D	483.20, 483.20(b) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the RAI specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information	F 272	**F 272 *Amended* Plan of Correction:** The Facility will continue to conduct an initial and periodic comprehensive assessment for each resident's functional capacity. **Findings 1 – 3:** An Interdisciplinary Team will convene and reassess the use of full side rails for Residents #5, #6 and soft waist restraints for Resident #30. The reassessment and restraint reduction plan will be discussed and documented on the Interdisciplinary Team Conference record and reflected on the patient care plan. If the Team determines full side rails or soft waist restraints are still indicated, a consent and corrective MDS will be completed as needed. During a unit based staff meeting, the Supervising Registered Nurses will educate staff on their responsibilities to routinely reassess the need for restraints and measures to reduce and or eliminate restraints, per Veterans Home policy.	

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F 272	Continued From Page 6 regarding the additional assessment performed through the resident assessment protocols; and Documentation of participation in assessment. This Requirement is not met as evidenced by: Based on observation, interview and record review the facility failed to ensure periodic, comprehensive, accurate assessments when 3 of 30 sampled residents lacked evidence of current assessments for the use of physical restraints (Residents 5, 6 & 30). Findings: 1. On 4/22/08 at 9:30 a.m. Resident 6 was in bed and had both full side rails up. The resident stated that he did not like having both rails up. Review of the resident's Minimum Data Set (MDS) assessment tool dated 4/5/08 and 1/8/08 indicated that both side rails were used. The resident's Full MDS completed 11/9/07 indicated no side rails. The last Interdisciplinary team conference documentation dated 4/8/08 failed to indicate that the resident used full side rails and that an assessment had been done. 2. During observations on 4/21/08 at 11:50 a.m., Resident 5 was in bed with full side rails up. Review of the clinical record indicated that the last assessment and consent for siderails was dated 8/14/06. The most recent MDS dated 2/14/08 indicated no restraints. An MDS dated 11/08/07 indicated an assessment was completed after a significant change with a decline in activities of daily living. There was no evidence in the clinical record that the resident had been reassessed for the use of side rails at the time of the significant change, or since. During an interview on 4/22/08 at 3 p.m., SRN	F 272	**Continued from page 6:** **Responsible**: Supervising Registered Nurse **Monitor**: The Interdisciplinary Team will audit the medical record quarterly to ensure residents utilizing restraints are reassessed routinely, according to Veterans Home policy and procedure.	05/21/08

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F 272	Continued From Page 7 Staff G stated that there should be a restraint assessment in the record and restraints are reassessed quarterly. Staff G agreed this information was not present in the record. 3. During observations on 4/23/08 at 11:30 a.m., Resident 30 was in a wheel chair with a soft non-releasable waist restraint. The most recent MDS completed on 4/14/08 indicated that the resident used a trunk restraint. The Resident Assessment Protocol (RAP) regarding use of the restraint read: "seatbelt utilized in wheel chair as requested by her family." Review of the clinical record indicated that the most recent quarterly interdisciplinary team meeting document dated 4/15/08 failed to address the use of the non-releasable waist restraint. The last "Restraint Needs Assessment" document dated 2/4/02 identified the current restraint in use as a "Posey lap belt" and recommended a "merry walker". During an interview on 4/24/08 at 8:30 a.m., C.N.A. Staff K stated that this resident no longer walks except using her feet to mobilize her wheel chair. The most recent nursing weekly summary dated 4/20/08 did not address the resident's use of a waist restraint. During an interview on 4/24/08 at 10:30 a.m., SRN Staff J stated that the team talks about restraints at each Interdisciplinary team meeting and "if we feel we need to do a reduction we will." Review of the facility policy titled: "Bedrails, Hazards Nsg 02-004 The Interdisciplinary team provides assessment and evaluation, both initially and quarterly, for bed side rails for potential entrapment". Review of the policy titled "Restraint Reduction Nsg 18-041" page 2: "Routine Evaluations: The resident's continued need for restraints and measures to reduce the risk for functional decline are routinely evaluated	F 272		

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F 272	Continued From Page 8 quarterly during IDT..." and may include the reason the restraint was ordered, the type of restraint and when it is applied, length of time in use, and conditions that may increase the risk of falls.	F 272	**Continued from page 8:**	
F 279 SS=E	483.20(d), 483.20(k)(1) COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This Requirement is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure the development and revision of the comprehensive care plan to meet the residents needs in 4 of 30 sampled residents (Resident 30, 6, 7 & 27), when Resident 30 developed a urinary tract infection, when Resident 6 had a pressure sore, when Resident 7 was under the care of hospice	F 279	**F 279 Plan of Correction:** The Facility will continue to develop and revise the comprehensive care plan to meet the resident's individual needs. **Finding 1.** The care plan for Resident #30 was reviewed and revised to include monitoring for intake and output. Additional, interventions were added to address the Resident's history and risk for urinary tract infection. **Findings 2 - 3.** The care plan for Resident #6 was reviewed and revised to include interventions to prevent pressure sores related to shearing. Additional interventions were added to the care plan to address the Resident's use of padded side rails. **Finding 4.** The care plan for Resident #27 was reviewed and revised to address the resident's history and risk for urinary tract infection. **Finding 5.** The care plan for Resident #7 could not be revised, as the resident expired while on hospice.	

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F 279	Continued From Page 9 providers and when Resident 27 did not have monitoring for adequate hydration. Findings: 1. According to the record, Resident 30 is cognitively impaired and required moderate to maximum feeding assistance. Resident 30 developed a urinary tract infection that required treatment on 4/18/08. A plan of care dated 4/21/08 identified, under Problem #4, poor intake and encourage intake of fluids. Review of the meal percentage intake documentation did not identify fluid intake. The most recent "Dietary Follow Up Report" dated 4/17/08 indicated that the resident's meal intake had been declining with an average intake of 25-45 %. During an interview with SRN Staff J, there was no method in place to monitor the resident's fluid intake apart from the entire meal consumption percentage documented before and after the resident developed a urinary tract infection. 2. According to the record, Resident 6 developed a Stage II pressure ulcer on his coccyx that was identified on 3/27/08. During an interview on 4/22/08 at 3 p.m., SRN Staff G stated that it was determined that the resident may have developed the pressure sore as a result of shearing during transfer with the mechanical lift. Review of the resident's plan of care dated 4/8/08 failed to identify preventive measures related to this possible cause in order to minimize its recurrence. As of 4/22/08 the resident's plan of care identified the problem of skin integrity with interventions that included reposition, and to keep clean and dry. 3. Resident 6 had a plan of care dated 4/8/08 that identified a problem of a history of bruising. On 4/22/08 the resident was in bed and noted	F 279	**Continued from page 9:** During a unit based staff meeting, the Supervising Registered Nurses will educate staff on their responsibilities regarding development and revision of the care plan to meet the resident's individual needs. Emphasis will focus on developing preventative care plans for urinary tract infections and pressure sores and for coordinating facility care plans with hospice. **Responsible:** Supervising Registered Nurse **Monitor:** The Interdisciplinary Team will audit and revise the residents' care plan quarterly. The Supervising Registered Nurse will ensure the care plan is developed and revised according to the team's recommendations.	05/21/08

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F 279	Continued From Page 10 with a large bruise on and around the left elbow area. There was a pad that covered the right side rail but nothing on the left rail. During an interview on 4/22/08 at 3:10 p.m., Staff G stated there would be another pad put on the other railing and had no information regarding the reason there was only one railing pad in use. Review of the resident's plan of care failed to identify the intervention of railing pads. 4. A review of Resident 27's MDS on 4/24/08, at 10:30 a.m, indicated he is incontinent, demented, had a decreased oral intake and uses a wheel chair from which he had a fall and sustained a hip fracture within the last 180 days. During a subsequent interview with the Unit Supervising Nurse, it was explained that during his hospitilization for the repair of the hip fracture it was discovered that Resident 27 had an undiagnosed urinary tract infection. The Supervising Nurse stated that in retrospect, it was thought by the interdisciplinary team that physical stress of the UTI caused some confusion for Resident 27 and resulted in his fall from his wheelchair. A review of the nursing care plans for Resident 27, on 4/24/08 at 10:50 a.m. indicated that his fall risk had been addressed, however there was not a specific care plan addressing Resident 27's risk for UTIs. His incontinence and toileting were addressed but the care plan addressing his decreased oral intake did not included an intervention to encourage and monitor fluid intake for adequate hydration related to his UTI risk. During the interview, the Supervising Nurse responded that Resident 27's need to be encourage to take fluids had been assessed, but had not been included in his care plans.	F 279		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555095	A. BUILDING _____ B. WING _____	04/24/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
N M HOLDERMAN MEMORIAL HOSPITAL D/P SNF	100 CALIFORNIA DRIVE YOUNTVILLE, CA 94599

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F 279	Continued From Page 11 5. A review of Resident 7 's record on 4/22/08 at 11:15 a.m. indicated that the resident is a hospice patient since 2/29/08 due to general decline and debility. The resident has received wound care every three days for an ischemic (due to deficient blood supply) ulcer on his left heel. The hospice nurse provided this care and other wound care and assessments during her intermittent visits to the facility. There was not a hospice care plan that outlined what specific care was to be provided by the hospice nurse or other employees of the hospice who provided care and services to the resident. There was also no calendar, in the record or on the unit, to indicate when hospice personnel would visit the resident. In an interview with facility staff on 4/22/08 at 11:30 a.m., she stated that the hospice nurse sometimes comes every day or every other day during the week and that when the hospice nurse is in the facility she provides the wound care to the resident. The staff could not say exactly when the next visit by the hospice nurse was due. The staff stated that the wound care to be provided is noted on the resident 's Medication Administration Record and would be done by facility staff if the hospice nurse did not show up on the day that the wound care was due. She stated that the hospice nurse was very good about discussing the resident 's care with the facility staff. In an interview with Facility Staff D on 4/22/08 at 4:30 p.m., they acknowledged that there was no hospice care plan or visit calendar in Resident 7 's record or on the unit. The facility failed to ensure that the hospice care plan was developed and integrated into the care plans that the facility had for the resident.	F 279		

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F 281	Continued From Page 12	F 281	**Continued from page 12:**	
F 281	483.20(k)(3)(i) COMPREHENSIVE CARE PLANS The services provided or arranged by the facility must meet professional standards of quality. This Requirement is not met as evidenced by: Based on observation and record review, the facility failed to provide services that met professional standards of quality by not following physicians orders for TED hose to be applied and a Roho cushion to wheelchair for sampled Resident 18 and TED hose to be applied for sampled Resident 27. Findings: 1. A review of Resident 18's record indicated a Physician's Order for: "TED hose as ordered...apply at 6a.m and remove at hour of sleep..." and "Roho cushion to wheel chair." At 1:45 p.m on 4/21/08 Resident 18 was observed in bed without TED hose and his wheelchair was observed without a Roho cushion. When the CNA providing care to Resident 18 was asked about the TED hose and the Roho cushion she responded that she did not know about the TED hose and did not know where to find the Roho cushion. 2. A review of Resident 27's record indicated a Physician's Order for: "TED hose. Remove at hours of sleep and apply every a.m upon rising."	F 281	**F 281 Plan of Correction:** The Facility will continue to develop and revise the comprehensive care plan to meet the resident's individual needs. **Findings 1 – 2.** Residents #18 and #27s TED hose were promptly applied. The CNA assignment sheets for both residents were revised to included specific instructions regarding the physician's order for TED hose. Resident #18's need for a wheelchair cushion was evaluated by Occupational Therapy. The appropriate wheelchair cushion was placed on the wheelchair. The Resident's care plan was updated accordingly. During a unit based staff meeting, the Supervising Registered Nurses will educate staff on their responsibilities regarding development and revision of the care plan to meet the resident's individual needs. Emphasis will focus on ensuring physician's orders are communicated effectively and implemented as ordered. **Responsible:** Supervising Registered Nurse **Monitor:** The Interdisciplinary Team will audit and revise the residents' care plan quarterly. The Supervising Registered Nurse will ensure the care plan is developed, revised, and implemented according to the Teams' recommendations.	05/21/08

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F 281	Continued From Page 13 On 4/24/08 at 1:30 a.m, Resident 27 was observed up in his wheelchair and he was not wearing TED hose. The Supervising Nurse was informed, and after checking the record and the physician's order, told a CNA to apply the TED hose to Resident 27.	F 281	**Continued from page 13:**	
F 286 SS=D	483.20(d) RESIDENT ASSESSMENT - USE A facility must maintain all resident assessments completed within the previous 15 months in the resident's active record. This Requirement is not met as evidenced by: Based on document review and interview, the facility failed to maintain all resident assessments done within the previous 15 months in sampled Resident 7 's record. Findings: A review of Resident 7 's record indicated that the MDS assessments for the resident only went back to 6/04/07. The only full assessment was a Significant Change assessment that was dated 2/27/08 and no annual assessment was in the record. In an interview with facility staff on 4/23/08 at 8:25 a.m., she acknowledged that 15 months of MDS assessments were not in the record. She stated that she was not aware that the record was supposed to contain the previous 15 months of MDS assessments. Another staff member stated that she had thinned the record because it was so thick and did not know that the record was supposed to contain the previous 15 months of MDS assessments.	F 286	**F 286 Plan of Correction:** The Facility will ensure the resident assessments completed within the previous 15 months are in the resident's active record. Resident assessments completed within the previous 15 months were promptly placed in Resident #7's active record. Using Nursing Service policy "Order of Filing," Supervising Registered Nurses will educate staff on their responsibilities regarding maintaining 15 months of the completed MDS assessments in the active record. **Responsible:** Supervising Registered Nurse **Monitor:** The Ward Clerk will audit the medical record for all residents to ensure 15 months of completed MDS assessments are maintained in the active record.	05/21/08

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F 425	Continued From Page 14	F 425	**Continued from page 14:**	
F 425 SS=D	483.60(a),(b) PHARMACY SERVICES The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. This Requirement is not met as evidenced by: This requirement is not met as evidenced by: Based on interview, record review, and facility document review, the facility failed to follow their policy for "Controlled Substances" for one unsampled resident(Resident 31). Findings: An interview with pharmacy Staff B was done on 4/23/08 at approximately 2:35 p.m. Staff B stated that a dose of Morphine solution should be written in milligrams on the Controlled Substance Administration Record.	F 425	**F 425 Plan of Correction:** The Facility will continue to provide pharmaceutical services to meet the needs of each resident. The Controlled Substance Record was corrected to reflect specific dose administered to Resident #31. During a unit based staff meeting, the Supervising Registered Nurses will educate staff on their responsibilities for accurately recording controlled substances according to Pharmacy policy and procedure. **Responsible:** Pharmacy Services and Supervising Registered Nurse **Monitor:** Pharmacy Services will conduct a monthly audit of the Controlled Substance Record documents for accuracy and adherence to policy. Pharmacy Services will report findings to the respective Supervising Registered Nurse. The Supervising Registered nurse will be responsible for prompt corrective action.	05/21/08

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F 425	Continued From Page 15 A review of Resident 31's record, on 4/22/08 at approximately 10:30 a.m., disclosed a physician's order dated 2/28/08 for Morphine Sulfate,.5 milliliters (10 milligrams), every 4 hours as needed for pain. A review of the Controlled Substance Administration Record on 4/22/08 at approximately 10:00 a.m. reflected that Resident 31 received a dose of Morphine solution and under "dose" the documentation indicated "one". A review of the facility's Pharmacy Policy on 4/23/08 entitled, "Controlled Substances" - Administration, the policy indicated, "Dose should be indicated in the units as printed on the form, (for example cc's, milligrams, etc.).	F 425	**Continued from page 15:**	
F 441 SS=D	483.65(a) INFECTION CONTROL The facility must establish and maintain an infection control program designed to provide a safe, sanitary, and comfortable environment and to prevent the development and transmission of disease and infection. The facility must establish an infection control program under which it investigates, controls, and prevents infections in the facility; decides what procedures, such as isolation should be applied to an individual resident; and maintains a record of incidents and corrective actions related to infections. This Requirement is not met as evidenced by: Based on observation the facility failed to maintain an infection control program to prevent the development and transmission of disease and infection. Findings:	F 441	**F 441 Plan of Correction:** The Facility will ensure the infection control program provides a safe, sanitary and comfortable environment. During a unit based staff meeting, the Supervising Registered Nurses will educate staff on their responsibilities to ensure medication spoons are stored and handled in a sanitary manner. **Responsible**: Supervising Registered Nurse **Monitor**: Using the Environmental Rounds Monitor, the Supervising Registered Nurse will monitor monthly to ensure utensils and medications are maintained in a safe sanitary condition.	05/21/08

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F 441	Continued From Page 16 During a medication pass observation on Unit 2A on 4/22/08 at 8:05 a.m, the Licensed Vocational Nurse (LVN) administering the medications pulled plastic spoons from a cup by the scoop end. The LVN did not wear gloves and all of the spoons were stacked in a paper cup with the handles down so that she could only get them out by pulling on the spoon scoop with her fingers. When the infection control concern was brought to the LVN's attention she responded that she agreed it was a problem. She stated that she would speak to the Supervising Nurse of the unit about making all unit staff aware that spoons used for the medication pass should be stacked so that they could be picked up by the handles only..	F 441		